AMENDED IN SENATE JUNE 24, 2010

AMENDED IN SENATE APRIL 27, 2010

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AMENDED IN ASSEMBLY MAY 6, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 1542

Introduced by Assembly Member Jones

March 4, 2009

~~An act to add Part 3.6 (commencing with Section 15950) to Division 9 of the Welfare and Institutions Code, relating to health care services.~~ *An act to add Chapter 3.34 (commencing with Section 1596.55) to Division 2 of the Health and Safety Code, relating to medical homes.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1542, as amended, Jones. Medical homes.

~~Existing law imposes various functions and duties on the State Department of Health Care Services with respect to the administration and oversight of various health programs and facilities, including the Medi-Cal program.~~

Existing law provides for the licensure and regulation of clinics and health facilities by the State Department of Public Health. Existing law also provides for the registration, certification, and licensure of various health care professionals and sets forth the scope of practice for these professionals.

This bill would establish the Patient-Centered Medical Home ~~Pilot Project~~ *Act of 2010* to encourage *licensed* health care providers and patients to partner in a patient-centered medical home, as defined, that

promotes access to high-quality, comprehensive care, *in accordance with prescribed requirements.*

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Chapter 3.34 (commencing with Section 1596.55) is added to Division 2 of the Health and Safety Code, to read:

CHAPTER 3.34. PATIENT-CENTERED MEDICAL HOME ACT OF 2010

1596.55. (a) This chapter shall be known, and may be cited, as the Patient-Centered Medical Home Act of 2010.

(b) It is the intent of the Legislature to encourage licensed health care providers and patients to partner in a patient-centered medical home that promotes access to high-quality, comprehensive care and ultimately to ensure that all Californians have a medical home.

(c) It is the intent of the Legislature that a California practice or other entity calling itself a medical home adhere to quality standards that will do all of the following:

(1) Reduce disparities in health care access, delivery, and health care outcomes.

(2) Improve quality of health care and lower health care costs, thereby creating savings to allow more Californians to have health care coverage and to provide for the sustainability of the health care system.

(3) Integrate medical, mental health, and substance abuse care.

(4) Remove barriers to receiving appropriate health care.

(d) It is further the intent of the Legislature that payors recognize the added value of a medical home by providing additional payment for the increased services and overhead associated with this practice model, including, but not limited to, all of the following:

(1) Coordination of care within the practice and between consultants, ancillary providers, and community resources.

(2) Adoption and use of health information technology for quality improvement.

(3) Increased patient access through advanced appointment systems, electronic patient portals, secure electronic mail, remove access monitoring systems, and telephone consultations.

(4) Risk adjustments based on the case mix, type and severity of patient illness, and patient age for the patient population.

(5) Provision for monetary reimbursement for added services among the various payment systems, including fee-for-service, value-added global, shared savings, and capitated payments.

1596.56. As used in this chapter, the following terms have the following meanings:

(a) (1) "Medical home," "patient-centered medical home," "advanced practice primary care," "health home," and "primary care home" all mean a health care delivery model in which a patient establishes an ongoing relationship with a physician or other licensed health care provider acting within the scope of his or her practice, working in a physician-led practice team to provide comprehensive, accessible, and continuous evidence-based primary and preventative care, and to coordinate the patient's health care needs across the health care system in order to improve quality and health outcomes in a cost-effective manner.

(2) A health care delivery model specified in paragraph (1) stresses a team approach to providing comprehensive health care that fosters a partnership among the patient, the licensed health care provider acting within his or her scope of practice, other health care professionals, and, if appropriate, the patient's family.

(b) "Practice" means a clinic that is exempt from licensure pursuant to subdivision (a) of Section 1206 that is owned and operated by persons authorized by law to provide comprehensive medical services to patients or a primary care clinic that is licensed under subdivision (a) of Section 1204.

(c) "Other entity" means a hospital-affiliated primary care clinic or a clinic that is owned and operated by a county or the University of California.

1596.57. Notwithstanding any other provision of law, no practice or other entity shall represent itself as a medical home unless it includes all of the following characteristics:

(a) Individual patients have an ongoing relationship with a physician or other licensed health care provider acting within his or her scope of practice, who is trained to provide first contact and continuous and comprehensive care, or if appropriate, provide

referrals to health care professionals that provide continuous and comprehensive care.

(b) A team of individuals at the practice level collectively take responsibility for the ongoing health care of patients. The team is responsible for providing for all of a patient's health care needs or taking responsibility for appropriately arranging health care by other qualified health care professionals. This responsibility includes health care at all stages of life including provision of acute care, chronic care, preventive services, and end-of-life care.

(c) Care is coordinated and integrated across all elements of the complex health care system and the patient's community. Care is facilitated, if available, by registries, information technology, health information exchanges, and other means to ensure that patients receive the indicated care when and where they need and want the care in a culturally and linguistically appropriate manner.

(d) All of the following quality and safety components:

(1) The medical home advocates for its patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between providers, the patient, and the patient's family.

(2) Evidence-based medicine and clinical decision support tools guide decisionmaking.

(3) Licensed health care providers in the medical practice who accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

(4) Patients actively participate in decisionmaking and feedback is sought to ensure that the patients' expectations are being met.

(5) Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

(6) The medical home participates in a voluntary recognition process conducted by an appropriate nongovernmental entity to demonstrate that the practice has the capabilities to provide patient-centered services consistent with the medical home model.

(7) Patients and families participate in quality improvement activities at the practice level.

(e) Enhanced access to health care is available through systems such as open scheduling, expanded hours, and new options for

communication between the patient, the patient's personal provider, and practice staff.

1596.58. Nothing in this chapter shall be construed to do any of the following:

(a) Permit a medical home to enter into a contractual relationship that may result in the unlicensed practice of medicine.

(b) Change the scope of practice of physician and surgeons, nurse practitioners, or other health care providers.

(c) Affect the ability of a nurse to operate under standard procedures pursuant to Section 2725 of the Business and Professions Code.

~~SECTION 1. Part 3.6 (commencing with Section 15950) is added to Division 9 of the Welfare and Institutions Code, to read:~~

~~PART 3.6. PATIENT-CENTERED MEDICAL HOME PILOT PROJECT~~

~~15950. (a) There is hereby established the Patient-Centered Medical Home Pilot Project.~~

~~(b) It is the intent of the Legislature to encourage health care providers and patients to partner in a patient-centered medical home that promotes access to high-quality, comprehensive care and ultimately to ensure that all Californians have a medical home.~~

~~(c) It is further the intent of the Legislature that a California provider, practice, or institution calling itself a medical home adhere to nationally recognized quality standards that will do all of the following:~~

~~(1) Reduce disparities in health care access, delivery, and health care outcomes.~~

~~(2) Improve quality of health care and lower health care costs, thereby creating savings to allow more Californians to have health care coverage and to provide for the sustainability of the health care system.~~

~~(3) Meet the National Committee for Quality Assurance (NCQA) definition and characteristics of a medical home.~~

~~15951. As used in this part, the following terms have the following meanings:~~

~~(a) "Medical home" means a team approach to providing health care that fosters a partnership among the patient, the personal provider and other health care professionals, and, where~~

~~appropriate, the patient's family, utilizes the partnership to access all medical and nonmedical health-related services needed by the patient and the patient's family to achieve maximum health potential, maintains a comprehensive record of all health-related services to promote continuity of care, and has all of the characteristics that qualify it as a medical home.~~

~~(b) "National Committee for Quality Assurance" means the nationally recognized, independent nonprofit organization that measures the quality and performance of health care and health care plans in the United States, provides accreditation, certification, and recognition of programs for health care plans and programs, and is recognized in California as an accrediting organization for commercial and Medi-Cal-managed care organizations.~~

~~(c) "Personal provider" means the patient's first point of contact in the health care system with a primary care provider who identifies the patient's health needs, and, working with a team of health care professionals, provides for and coordinates appropriate care to address the health needs identified.~~

~~(d) "Primary care" means health care that emphasizes providing for a patient's general health needs and utilizes collaboration with other health care professionals and consultation or referral as appropriate to meet the needs identified.~~

~~15952. A "medical home," for the purposes of this part, meets the standards set forth by the National Committee for Quality Assurance, and includes all of the following characteristics:~~

~~(a) An ongoing personal provider for each patient trained to provide first contact, continuous, and comprehensive care.~~

~~(b) The personal provider leads a team of individuals at the practice level who collectively take responsibility for the ongoing health care of patients.~~

~~(c) The personal provider is responsible for providing for all of a patient's health care needs or taking responsibility for appropriately arranging health care by other qualified health care professionals. This responsibility includes health care at all stages of life including provision of acute care, chronic care, preventive services, and end-of-life care.~~

~~(d) Care is coordinated and integrated across all elements of the complex health care system and the patient's community. Care is facilitated by registries, information technology, health information exchanges, and other means to ensure that patients receive the~~

~~indicated care when and where they need and want the care in a culturally and linguistically appropriate manner.~~

~~(e) All of the following quality and safety components:~~

~~(1) Provider-directed medical practices advocate for their patients to support the attainment of optimal, patient-centered outcomes defined by a care planning process driven by a compassionate, robust partnership between providers, the patient, and the patient's family.~~

~~(2) Evidence-based medicine and clinical decision support tools guide decisionmaking.~~

~~(3) Providers in the medical practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.~~

~~(4) Patients actively participate in decisionmaking and feedback is sought to ensure that the patients' expectations are being met.~~

~~(5) Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.~~

~~(6) Practices participate in a voluntary recognition process conducted by an appropriate nongovernmental entity to demonstrate that the practice has the capabilities to provide patient-centered services consistent with the medical home model.~~

~~(7) Patients and families participate in quality improvement activities at the practice level.~~

~~(f) Enhanced access to health care is available through systems such as open scheduling, expanded hours, and new options for communication between the patient, the patient's personal provider, and practice staff.~~

~~(g) The payment system appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure framework of the medical home does all of the following:~~

~~(1) Reflects the value of provider and nonprovider staff and patient-centered care management work that is in addition to the face-to-face visit.~~

~~(2) Pays for services associated with coordination of health care both within a given practice and between consultants, ancillary providers, and community resources.~~

~~(3) Supports adoption and use of health information technology for quality improvement.~~

~~(4) Supports provision of enhanced communication access such as secure electronic mail and telephone consultation.~~

~~(5) Recognizes the value of provider work associated with remote monitoring of clinical data using technology.~~

~~(6) Allows for separate fee-for-service payments for face-to-face visits. Payments for health care management services that are in addition to the face-to-face visits do not result in a reduction in the payments for face-to-face visits.~~

~~(7) Recognizes case mix differences in the patient population being treated within the practice.~~

~~(8) Allows providers to share in savings from reduced hospitalizations associated with provider-guided health care management in the office setting.~~

~~(9) Allows for additional payments for achieving measurable and continuous quality improvements.~~

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